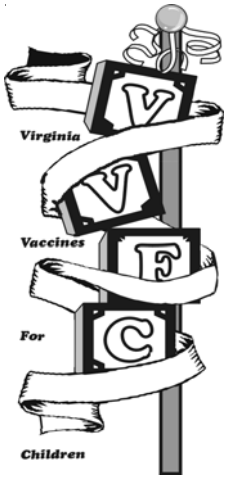

VIRGINIA VACCINES FOR CHILDREN REGISTRATION FORM

PIN

REFER TO SUPPLEMENTAL INSTRUCTIONS FOR ASSISTANCE.

DATE _____

Please select one:

☐ **THIS IS MY FIRST REGISTRATION WITH VVFC.**

NOTE: A 30 DAY TEMPERATURE LOG IS REQUIRED TO BE SUBMITTED WITH ALL FIRST TIME REGISTRATIONS.

☐ **THIS IS A RENEWAL OF MY EXISTING REGISTRATION WITH VVFC.**

FACILITY NAME_____

SECTION 1: VACCINE SHIPPING INFORMATION

Provide a VVFC contact and facility address below for all *vaccine shipments*.

SHIPPING CONTACT AND TITLE _____

VACCINE DELIVERY ADDRESS (NO P.O. BOXES) _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ EXT _____ FAX NUMBER _____ EMAIL _____

_____

BUSINESS HOURS/DELIVERY HOURS OR ADDITIONAL DELIVERY INSTRUCTIONS (I.E. CLOSED WEDNESDAYS, DELIVER TO SIDE DOOR)

SECTION 2: VVFC MAILING INFORMATION

If different from above. Provide for all *VVFC correspondence*.

MAILING CONTACT AND TITLE _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SECTION 3: TYPE OF FACILITY

___ Private Practice

___ Hospital

___ Health Department

___ Free Clinic***

___ Federally Qualified Health Center (FQHC)* (Facility Medicaid number: _____)

___ Rural Health Clinic (RHC)** (Facility Medicaid number: _____)

___ FQHC/RHC "Look-alike"* (Facility Medicaid number: _____)

___ Other (please specify) _____

***Federally Qualified Health Center**: A center that provides health care to a medically underserved population may apply to the Bureau of Primary Health Care (BPHC) within the Health Resources Services Administration (HRSA) for FQHC status. FQHCs include community and migrant health centers, special health facilities such as those for the homeless and persons with AIDS that receive grants under the public Health Service Act, and "look-alikes" which meet qualifications, but do not actually receive grant funds.

****Rural Health Clinic**: A provider class under the Health Care Financing Administration (HCFA) that must meet certain qualifications for services provided and staffing.

*****Free Clinic**: A Free Clinic is a private, nonprofit, community-based or faith-based organization that provides health care at little or no charge to low-income, uninsured people through heavy use of volunteer health professionals and partnerships with other health-related organizations.

NEW ENROLLMENT

PIN

SECTION 4: PATIENT POPULATION

Indicate which patient populations the facility serves:

- **Medicaid PCP** Yes___ No___
- **Medicaid HMOs** Yes___ No___
- **Uninsured** (Self-pay patients) Yes___ No___

SECTION 5: PATIENT PROFILE

(HEALTH DEPARTMENTS DO NOT HAVE TO COMPLETE THIS SECTION)

List the number of patients receiving vaccines by age group and by category. If you are a new facility, please estimate the number of patients you will enroll within the next 12 months.

Patient Type	0-12 MONTHS	1-6 YEARS	7-18 YEARS	19 YEARS AND OLDER * (NOT VVFC ELIGBILE)	TOTAL
Total Patients at Facility					
Enrolled in Medicaid or Medicaid HMOs					
No Health Insurance					
American Indian or Alaskan Native					
Underinsured NOT VVFC ELIGBILE AT ALL FACILITIES. SEE BELOW FOR MORE INFORMATION.					
Patients with Private Insurance					

VVFC ELIGIBILITY

Patients are VVFC eligible if they are less than 19 years of age and meet one of the following criteria

- **Enrolled in Medicaid (includes Medicaid HMO, Medicaid MEDALLION, and Medicaid as secondary insurance)**
- **Uninsured (self-pay patient, does not have health insurance)**
- **American Indian or Alaskan Native**

Note: Underinsured, patients with health insurance which does not cover immunizations, are only eligible for VVFC at a FQHC or RHC facility.

*Some Non-VVFC Eligible patients may be eligible for free vaccines at certain public facilities (i.e. health department, FQHC, RHC, free clinic). For details, please refer to the Vaccine Use Guidelines under Public Providers at http://www.vdh.virginia.gov/imm/forms.asp.

SECTION 6: PHYSICIAN REGISTRATION

PIN

VVFC PROGRAM CONTRACT

To participate in the Virginia Vaccines For Children (VVFC) Program and receive federally procured vaccine provided to my facility at no cost, I, on behalf of myself and any and all practitioners associated with this medical office, group practice, Health Maintenance Organization, health department, community/migrant/rural clinic, or other entity of which I am the physician-in-chief or equivalent, agree to the following:

- VVFC program-purchased vaccine will be administered only to a child less than 19 years of age who (a) is in Medicaid (or qualifies through the State's Medicaid waiver); or (b) has no health insurance; or (c) is an American Indian or Alaskan Native; or (d) has health insurance that does not pay for the vaccine (applicable only to vaccines administered by or on behalf of a FQHC or RHC).
- I will maintain screening records of the child's authorized representative's responses to eligibility questions for a period of 3 years, and release of such records will be bound by the privacy protection of Federal Medicaid Law.
- If requested, I will make the eligibility response records and vaccine documentation available to the State Health Department or the Federal Department of Health and Human Services (DHHS).
- I will comply with the appropriate immunization schedule, dosage, and contraindications established by the DHHS Advisory Committee on Immunization Practices (ACIP).
- I will provide vaccine information materials and maintain records in accordance with the National Childhood Vaccine Injury Act, which includes reporting clinically significant adverse events to the Vaccine Adverse Event Reporting System.
- I will not impose a charge for the cost of the vaccine.
- The vaccine administration fee cannot exceed the maximum fee established by the state.
- I will not deny administration of a federally procured vaccine to a child due to the inability of the child's parent/guardian/ individual of record to pay an administration fee or due to any outstanding bill balances.
- I will comply with the State's requirements for vaccine ordering and usage reporting as well as the additional requirements outlined in the VVFC Fraud and Abuse policy.
- I, or the State, may terminate this agreement at any time for personal reasons or failure to comply with these requirements.

VVFC Main Contact Physician Name	Signature	Medicaid Number	Medical License Number	Date

SECTION 7: ADDITIONAL PRACTITIONER REGISTRATION

Additional practitioners licensed or otherwise authorized (i.e. pharmacist) for administration of pediatric vaccines under Virginia law at your facility should be listed below. If a new physician joins your facility or a physician leaves, please notify our office. (Attach additional paper if necessary)

VVFC Practictioner Name	Signature	Medicaid Number	Medical License Number	Date

SECTION 8: ADDITIONAL SITE INFORMATION

PIN

AFFILIATED SITES

Individually enrolled in VVFC

Affiliated Site #1

Address #1 Phone

Affiliated Site #2

Address #2 Phone

Affiliated Site #3

Address #3 Phone

SATELLITE LOCATIONS

Not Individually enrolled in VVFC

Satellite Site #1

Address #1 Phone

Satellite Site #2

Address #2 Phone

NOTE: VVFC RECOMMENDS ALL FACILITY LOCATIONS RECEIVE DIRECT VACCINE SHIPMENTS BY ENROLLING INDIVIDUALLY IN THE VVFC PROGRAM. CALL FOR DETAILS.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT THE VVFC OFFICE AT

(800) 568-1929 OR (804) 864-8055

VVFC@VDH.VIRGINIA.GOV

HTTP://WWW.VDH.VIRGINIA.GOV/IMM/VVFC.ASP

PLEASE RETURN FORM TO:

VIRGINIA VACCINES FOR CHILDREN
DIVISION OF IMMUNIZATION
P.O. BOX 2448
109 GOVERNOR STREET, ROOM 314 WEST
RICHMOND, VIRGINIA 23218
FAX: (804) 864-8090